Madison Family Clinic

Notice of Privacy Practices Acknowledgement & Consent Form

I understand that, under the HIPAA Act of 1996, I have certain rights to privacy regarding protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I understand that I have received Madison Family Clinic, *Notice of Privacy Practices* which contains a more complete description of the uses and disclosures of my health information. I understand that Madison Family Clinic has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Madison Family Clinic during normal office hours at (859) 626-7794 to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Madison Family Clinic restrict how my private information is used or disclosed to carry out treatment, payment, or health-care operations. I also understand that Madison Family Clinic is not required to agree to my requested restrictions, but if Madison Family Clinic does agree, then Madison Family Clinic is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

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Signature of patient / representative Date

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Printed name and relationship to patient

Madison Family Clinic Use Only

I attempted to obtain the patient / representative's signature in acknowledgement on this Notice of Privacy Practices and Consent Form, but was unable to do so as documented below.

Comments: ____

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Signature of staff person Date

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Print name and title